



Report
Round Table Discussion on TB – HIV as Policy Priority
April 13, 2008

Organized by:



HIV/ AIDS and STD Alliance Bangladesh (HASAB) Dhaka, Bangladesh

and

National AIDS STD Programme, DGHS
Ministry of Health & Family Welfare, Bangladesh

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1. Executive Summary

As HIV is fuelling a resurgence of TB in many countries of the world, the public Health Watch is working in all of which are designated as TB burden countries, to monitor and advocate and also improve the country policy. In 2006, HIV/AIDS & STD Alliance Bangladesh (HASAB) with the fund from Open Society Institute (OSI) initiated the "TB-HIV Monitoring and Advocacy Project" and has conducted a research work to improve the country policy on TB-HIV. In the second phase of the project, a round table discussion was arranged to share the findings of this research and also to get the insights of the health professionals and also the thoughts of the government on this issue, with an expectation of positive reflection at policy level. The major objectives of this round table discussion were to:

- ▶ raising TB-HIV as a key policy priority issue among the key players, such as government, donors, NGOs and others;
- ▶ bring the issues into discussions that includes- Stand Alone TB/HIV Policy, Inadequate Skill Mix Among Service Provider, and Lack of Information, Sensitivity in the Implementation Level; and
- ▶ build consensus on the recommendations on the above mentioned issues.

The round table discussion held on April 13, 2008. The discussion started with welcome address by Prof. Nazrul Islam. Chairman, EC committee, HASAB, mentioned that TB/HIV is a very priority topic at this moment and he started with thanks to everyone to join in the forum. The key note presenter Dr. Nazneen Akhter, Executive Director raised that, TB-HIV as time leading demand of Public Health issue. She highlighted some main findings of the research in her presentation and also told that we need a joint TB-HIV strategy plan where Program and Finance will also be inter-linked for a successful story. She told that it was a very short project funded by Open Society Institute (OSI) and HASAB got advisor from OSI. She also acknowledges the guidance of WHO and the team who was the part of the research, specially the sample of the research.

After the key note presentation, the discussion was divided in to three steps, which were facilitated by Dr. Mahmudur Rahman, Director IEDCR, Dr. Md. Hanif Uddin, DPM, NASP and Dr. Abul basher Md. Khosru, PM, NASP. The focused issues were: (1) Stand Alone TB/HIV Policy; (2) Inadequate Skill Mix Among Service Provider; and (3) Lack of Information, Sensitivity in the Implementation Level (Inadequacy in Management Information System; MIS). All participants actively participated in the discussion and came up with some specific recommendations to address the problem properly.

The house agreed that, training is required for the service providers on TB-HIV issue, existing policy documents should be revised, proper algorithm to reach both TB and HIV simultaneously in GO and NGO level need to be developed, referral linkage should be strengthen giving priority the TB-HIV together and MIS should be clear and simpler and in need of reviewed to include necessary column to address TB-HIV simultaneously.

Prof. Md. Abul Faiz, DG, DGHS, MOH&FW graced the occasion as Chief Guest and Dr. Mustafa Anower, ADG, Planning and Dev. DGHS and Line Director, NASP & SBTP Chaired the meeting.

2. Introduction

HIV/AIDS is fuelling a resurgence of TB in many countries of the world. Global incidents of TB have increased over the past three years, killing approximately 2 million people yearly. At the same time TB is leading cause of death by infectious disease for people living with HIV/AIDS and the lack of political commitment to TB control is striking.

In Bangladesh, over half of the population is infected with the TB bacillus; Tuberculosis is a leading cause of adult mortality and preventable death in Bangladesh. An estimated 70,000 individuals die from TB each year: one death every 10 minutes. One study estimated that uninfected individuals have greater than a 2 percent chance of becoming infected with TB in any given one-year period. TB hits the poor and the most economically productive age group hardest, wreaking devastating economic and social impact. Yet many Bangladeshis are unaware of the fact that TB is curable and that treatment is available at public health facilities free of charge. Given such high-risk behaviors as low condom use, rising HIV rates among high-risk groups (including drug users), and the fact that approximately half of the population is infected with the TB bacillus (raising the risk of progression to active infection); there is concern about the potential for a sharp rise in the rate of TB/HIV co-infection. Bangladeshi TB experts also express concern that official rates of Multi Drug-resistant TB (MDR-TB) underestimate the scale of the problem.¹ Still, there is no national representative study been undertaken neither by Bangladesh Government nor by any development partner to assess the knowledge level of general population on basics of TB and also about the basics of HIV/ AIDS. For a result, different studies or incidents have also revealed that misconceptions about both TB & HIV is also high in which TB or HIV patients used to face social denial.

The public Health Watch is working in Bangladesh, Brazil, Nigeria, Tanzania and Thailand and all of which are designated as TB burden countries, to monitor and advocate and also improve the country policy. As a part of that, HASAB has done the research work and now to improve the country policy on TB-HIV this round table discussion was arranged to get the insights of the health professionals and also the thoughts of the govt. on this issue which will reflect in the policy. TB-HIV is a co infection, so the goal of this dialogue was to coordinate the policy in TB and HIV/AIDS. In addition it may establish a linkage of programs on TB and HIV/AIDS.

To get rid of all this issues this a round table discussion was arranged at a high time on the DGHS conference room on the 13 th of April, 2008 that was a collaborative program of HASAB and NASP which funded by Open Society Institute (OSI). The meeting was chaired by Dr. SM Mustafa Anower, Additional Director General (planning and Development) and Line Director, DGHS and Prof. Md. Abul Faiz, DG, DGHS, MOH&FW graced the occasion as Chief Guest

¹ TB Policy in Bangladesh, A Civil Society Perspective, Open Society Institute

3. Participants

Representatives of relevant government agencies including DGHS of MOH&FW, NASP (National AIDS STD Programs), SBTP (Safe Blood Transfusion Program; representatives from WHO (World Health Organization; representatives from UN agencies and other donor agencies, NGOs and other stakeholders were presented in the Round Table Discussion. A list of the participant is attached herewith (*Annex-1*).

4. Moderators and Presenters

Dr. Nazneen Akhter, Executive Director, HASAB presented the Key Note Paper. Dr. SM Mustafa Anower, Additional Director General (planning and Development) and Prof Nazrul Islam. Chairman, EC committee, HASAB moderated overall discussions. Dr. Mahmudur Rahman, Director IEDCR, Dr. Md. Hanif Uddin, DPM, NASP and Dr. Abul basher Md. Khosru, PM, NASP moderated on selected and specific topics.

5. Overview of Discussion

I. Welcome Address

At the beginning of the discussion Prof Nazrul Islam. Chairman, EC committee, HASAB delivered his welcome note and started with thanks to everyone of the ground. He thinks this is a very priority topic TB/HIV at this moment. From many years there is a strong significant friendship between TB and HIV. Though TB was eradicated completely from the developed countries reemergence of TB is seen in developed and developing country. Another issue is that TB is emerging newly as co-infection with HIV. So we should think about TB with HIV because both are synergistic. He also mentioned that Directorate General of Health Services should start first as he is the keeper of health issue.

II. Key note presentation on TB-HIV as policy priority

Then, Dr. Nazneen Akhter, Executive Director, HASAB started with a background of this round table. She told that this is a very special issue of public health and HASAB is very much honored to have a findings sharing platform. She mentioned that it is a special discussion on TB-HIV as time leading demand of Public Health issue. On behalf of HASAB she welcomes everybody again as well as thanks all for participation. TB-HIV exists as priority issue in HASAB policy for last 4 years. On behalf of Governing body of HASAB she thanks DGHS for providing venue and also for being present in the program. She recognized again the participants and resource person who provided thoughtful insights in implementation of the program, the findings of which is going to be shared. She said again HASAB will go for implementation through policy and so from this dialogue how can we get a policy that can lead us to proper implementation is the main focus of the round table. She told that it was a very short project funded by Open Society Institute (OSI) and HASAB got advisor from OSI. She acknowledges the guidance of WHO and the team who was the part of the research, specially the sample of the research. This research was based on an in depth interview where PLHAs, TB clients, Policy maker all were the sample. She highlighted some main findings of the research in her presentation and also told that we need a joint TB-HIV strategy plan where Program and Finance will also be inter- linked for a successful story.

Dr. Nazneen , also emphasized on collective thinking with a join forces as public-privet partnership and wished that some thoughts from this dialogue will come up to light to achieve the goal of the discussion. It is emerging opportunity for all of us to act in collaboration.

III. Issue Specific Discussion:

Then the main discussion was run. Line Director, Dr. SM Mustafa Anower told that though we are being in different field but we can move by our all field workers, doctors, social workers in a full strength and this discussion will create a guideline to that goal. Then he started open discussion. The round table discussion focused three issues:

- a. Stand Alone TB/HIV Policy:
- b. Inadequate Skill Mix Among Service Provider
- c. Lack of Information, Sensitivity in the Implementation Level (Inadequacy in Management Information System; MIS)

Three issues for the discussion were distributed to three key persons to be facilitated

- “Stand alone TB and HIV policy” goes to Dr. Mahmudur Rahman, Director IEDCR for facilitation and it was decided that regarding the issue 2 points may be discussed- 1) Existing Status issue and 2) How can we overcome existing status through coordination
- “Inadequate skill mix among service provider” goes to Dr. Md. Hanif Uddin, DPM, NASP for facilitation and decision was that it will be discussed according to – we should develop strategy instantly and constantly
- “Lack of information, sensitivity in the implementation level (inadequacy in Management Information System; MIS) goes to Dr. Abul basher Md. Khosru, PM, NASP. It was decided that the issue would be discussed with the view to make it simple and informative but furnished with necessary information through effective communication and coordination.

The key points of the three discussed issues are as follows accordingly:

(a) Stand Alone TB/HIV Policy:

This session was moderated by Dr. Mahmudur Rahman, Director IEDCR that focused the present situation in which we are now, and also how can we work in a collaborative way and the proper plan for that goal.

Dr. Abul Basher Md. Khosru, PM, NASP told that we have to know first the present TB situation from rural level to national level. All information has to be in a same place and chronological order. How many TB patients do we have and where most of the TB exists has to be located and which of the GO- NGO fight for TB is also to be noticed. Without proper information flow in this regard we cannot work properly.

HIV facilities have not yet gone to the periphery. We do have HIV policy but if we want dual policy on TB-HIV we have to include all the medical college students also to make this fight a collaborative strength. The committee coordination on TB/HIV in this regard should be maintained from Head quarter to district level in a proper method. He also suggested that civil surgeon can lead in district level. Dr. khosru also highlights that in Bangladesh we are working

in the periphery level for TB, sometimes health professionals do home visit to the TB people and help them to have their medicine that is under DOTS program. But in HIV activities we don't see this sort of social works. Only 13 to 14 percent TB people provided by govt. services in Bangladesh and the rest by NGOs. So, we have to give a through look in the activities of NGOs regarding TB issue as they are serving the highest.

Dr. Md. Abdul Hamid Salim, Country Director and Medical Advisor, Damien Foundation told that HIV infection is still in limited level and he thinks every HIV and TB can be tested for vice versa. There are hundred districts under TB Control Program and doing work with thousands of TB positive people whether cure rate is 99% and Death rate is negligible. But the issue is there is no coordination between TB and HIV related services as we know that among opportunistic infections of HIV, TB is the most prevalent one. Now according to the reference of national data, prevalence of HIV is very low but if the situation is converted to 50%, the country really will be in disaster and it will be very much tough to manage the situation. Considering the situation- There should be provision of testing TB among diagnosed HIV infected regarding definite and set criteria.

In this point Dr. Rupali Sisir Banu, National Consultant add a point that 36 TB positive was found among 194 HIV positive in this country which is of course an emerge situation of this country. Linking with the information Facilitator Dr. Mahmudur Rahman, Director IEDCR told that, we also have to think about the co-infection giving it priority. He also raised one question that- *What we should do?* Will we do focus on TB and then go for HIV or first to HIV and then go for TB? This is the time to take decision about the issue for better coordination.

Dr. Kazi Belayet Ali, PM, SC-USA told- which will be addressed first is not the issue. If HIV Infected person arise symptom of TB can be screened for that and we have VCT center for this. But the problem is that all VCT are not in place and not equipped maintaining the standard. So collaboration needed in terms of center (TB and VCT), resource and quality which we have not yet done. One of the facilitator addressed that, in District level we can coordinate TB-HIV through civil surgeon that will be more effective. Representative of National TB Control Project, Shyamoli, mentioned that according to each and every HIV positive patient should be tested for TB at definite interval.

Dr. Mariam Ba, Consultant, WHO , advised as Bangladesh have not enough financial and human resource, it is not possible to test all TB patients to test for HIV. But we can do set some criteria for TB patient to screen for HIV like-

- Not responding to Anti-TB drug
- Involved in high risk behavior like- DUs, Sex workers. **Dr. Mariam Ba**, also add that, Bangladesh is high prevalent country of TB and low of HIV/AIDS. We should be prepared because 50% of people are in threat of TB here. It is not possible to screen all TB people because they are huge in size and Bangladesh has not sufficient VCT. But we can test the selected people and also we can test all HIV positive people whether they are carrying TB or not. All the people have to get facilities from the root level and we have to work in district level for this. If we want a formal TB policy than we must need proper documents and still there are scope to work in this area. Moreover if there is any TB control policy it should be modified and formalized to make dual TB-HIV policy.

Facilitator summarized discussion regarding the topic:

- ▶ Existing policy documents should be revised;
- ▶ TB policy should include co infection concern;
- ▶ All the documents- formalized and nonformalized should be concerned of TB-HIV co-infection;

(b). Inadequate Skill Mix among Service Provider:

This topic was moderated by Dr. Md. Hanif Uddin, DPM, NASP. Dr. Hanif told that, we have sufficient service provider but we cannot cover the need properly. There is still lacking in TB-HIV collaboration. That's why some people are working with HIV people and some other are involved in TB. But if we can provide HIV training to all the service providers dealing with TB that would be a great initiatives and vice versa. Then we can move forward with our skilled service provider both in TB and HIV to achieve the goal. We have to overcome this limitation.

He also mentioned that if we go to make a policy it will take much more time as because this process is too much time consuming and so we can go for a strategy plan immediately for TB-HIV

Dr. Belayet, PM, SC-USA told at this point that, our health workers are nor updated regularly and also the young doctors and students are not updated in a true sense. So, we need to capacitized them immediately and also the all GO NGO health workers.

Representative from BRAC, DR. Mahfuza Rifat, Program Specialist said that they have trained around 10,000 provider on TB with some basic orientation on HIV.

Dr. Shishir, Consultant, WHO, told that in TB program they identified the HIV partners and vice versa. . She also mentioned that they have module on TB training and we are doing capacity building of our NTP partners. Now we are going to do capacity building for them through our revised module where we have included TB-HIV as a coinfection. They also go for evidence based experience and she suggested that special activity need for Dhaka city as it is the major zone for IDU's

Dr. Nazneen, ED of HASAB told, strategy should be exist or developed so that it would be participant focused. There should be an algorithm of services with the view of coordination between TB and HIV that can be initiated from TB and than to HIV or opposite. We should develop some tool to identify client for HIV test who are suffering from Tuberculosis. In government setting there are TB setting for providing DOTS but no counseling service provision. We should create it and this is called skill mix. Regarding obtainable peer module we can do better. There is existing peer approach in TB program as well as in HIV program; we are only in need of coordination.

Dr. Nilufar from AAS said that it is very difficult to diagnose TB among HIV positive because most of them are victim of extra pulmonary TB. Ashar Alo Society's participants also told that

they have 136 PLHAs and among them 36 are TB infected. And among 36 TB 10 are negative in TB test and it was very difficult to diagnose the TB of the HIV people.

Dr. Nazneen, ED, HASAB shared at this point that, when HASAB took research on this issue most of the participants wished to have strategy rather than policy. She thinks selective TB people can be tested to determine HIV according to definite criterion. And we can develop a PR model as a continued effect.

Dr. Hanif mentioned here that, we have lots of workers on TB and NTP is working nice. He also told skill mixing among the service provider is a compulsory at this moment.

Facilitator summarized discussion regarding the topic:

- ▶ We have to develop referral linkage for better coordination between TB and HIV and for getting integrated, harmonized and synchronized services with the view to minimize probable harm and disease burden of TB-HIV.
- ▶ We should develop proper algorithm to reach both TB and HIV simultaneously in GO and NGO level which can be the proper way of skill mix to minimize existing and upcoming problem regarding the issue

(c) “Lack of information, sensitivity in the implementation level (inadequacy in Management Information System; MIS)”:

This session was moderated by Dr. Abul basher Md. Khosru, PM, NASP and it was an on MIS.

On this issue Dr. Mahfuza Rifat, Program Specialist, TB from BRAC told that BRAC is following NTP format for MIS. Representative of BRAC said- they are following NTP format and it need to be revised and include provision of providing information about how many of the TB positive are tested for HIV and how many of them are HIV positive simultaneously .

Dr. Hanif mentioned at this point that, BRAC and Damein Foundation are working on TB in district level and there are 31 reporting format. He expressed confusion whether all these reporting system is supporting properly!! Rather we can follow a very simple reporting system to have all the records at a glance.

Dr. Shishir told that we have to give a complete revision on the existing tools and techniques. We should have initiatives in mainstreaming of MIS. The number of tools and techniques have to be unified MIS which are not existing now. Giving importance to TB-HIV, partners are suggesting to include necessary indicators. We have to develop uniformate regarding MIS using the indicators which will be reflected in country report.

Dr. Mahmudur Rahman, IEDCR told that we are still in a process to integrate all these things. He mentioned some indicators may be exist in MIS such as, Core indicator, Program indicator and additional indicator and he thinks there is no need to make the report heavy and clumsy with unnecessary information beside which we have to have integrated surveillance system for better evaluation.

Dr. Nazneen Akhter mentioned here the MIS of YFHS. She also talked about the modern way of how we can put TB-HIV in a comparable column so that the MIS could be a presentable format.

Dr. Nazneen told that our problems are-

- Largeness of the structure
- To much information
- Unnecessary information

We have to think how it can be made simpler giving more emphasis on TB-HIV co infection and giving up unused information column in the same time.

Dr. Belayet, SC-USA told that most of the people, who work in MIS, put information nothing what they are doing at all. A parallel reporting system should be exist in this issue. Policy issue and primary health care system should be focused. Beside this we have to address the policy issue and advocacy issues together for perfect refresher of MIS.

Dr. Hasan Mahmud, DPM, NASP told that we really don't know from where we can get the proper information and we shouldn't violet the MIS rather we should have contain information of advocacy documents.

DR. Mahmudur Rahman, IEDCR said- we don't need information every month and every week. The interval should be set up accordingly.

Dr. Khosru, NASP told we have lots of MIS system (33) and sometimes it is a burden to us. So, accurate information should come to us in a smooth way without having any kind of complicity.

One major thing he mentioned is that, whenever we get any report on TB we have to update the HIV report simultaneously.

Facilitator summarized discussion regarding the topic:

- ▶ MIS should be clear and simpler and in need of review to include necessary column regarding address TB-HIV simultaneously and exclude the unnecessary portion for proper evaluation
- ▶ Actual information should come up from field

IV. Speech of Chief Guest

Then the honorable chief guest, Prof. Md. Abul Faiz delivered his valuable speech. Addressing all in stage he welcome everybody including participants of the event. He felt very much glad that this kind of policy dialog program is organized He said that question can arise that HIV prevalence is less in the country but why much discussion with the issue. he said again that the issue is that the case are less but people are vulnerable for getting HIV and after HIV infection people become more vulnerable for TB for their immunocompromised condition and another issue is, Bangladesh is the country of infection and complications.

He expressed his satisfaction for arranging this round table on policy dialogue of TB-HIV. He also told that it may be a question that we (Bangladesh) haven't much HIV but why do we have

arranging these initiatives. The main reason is that Bangladesh is a high prevalence of TB people and they might be infected with HIV that would be a double trouble! He also mentioned that Bangladesh is the fertile area for infection. He also shared the information that, in European country some research finding says that some infections such as TB is not curable at all and after a through treatment it may disappear for a certain period but in true sense some other time it may occur. He also told that TB-HIV coinfection, they are walking together like twins. If we have dual policy on TB-HIV, we can get it as a model and it will run with a full success.

In Bangladesh there are lots of TB people but limited HIV people. One thing we have to think and make a decision that which groups of TB people have to test HIV. And in this platform HASAB takes the initiatives. HASAB is thinking of how we can make our weakest infrastructure to a strengthening system. DG expressed that, by all of our collaborative effort and areas we can make a strong strengthening system. He also raised a questioned that we have lots of medical students, and can we make them knowledgeable and lots of field worker, nurses, social worker we have and how they are trained or well informed to serve the best in health issue. It is now the high time to think off.

We are addressing prevention of HIV among general and high risk population but we also have to prevent TB among HIV infected. We are in need of system strengthening for managing the double trouble (TB and HIV). We are in a emergency situation but we have the weakest structure where there is weak Public Health system that would not be able to address TB-HIV together. As an example we have a large number of students. Had we make them knowledgeable about health system and health issues like TB-HIV?

He said we should have mapping regarding who are working with TB, who are with HIV and who are with combined TB and HIV. So that system will be simple and understandable. Who are developing human resources also should be identified. He also noticed one main weak side of our health professionals that we need to make more strong is counseling. His observation is that they don't like to talk more. But the doctors or health professionals should talk more and more as because they are giving the information. And it is fact that we learn more through listening than to reading at a glance. So for smooth functioning of the programs on TB/HIV we have to make understand the health professional of the principles of counseling, the necessity of counseling in human life. How long patients have to take treatment, when one has to stop taking treatment in every steps counseling is mandatory. He also emphasized on the communication skill build up through counseling in health sector. DG wished that, If we identify the key points and policy through discussion will be fruitful as there are many expert people are here and.

He mentioned to have a map of combined effort of all the GO-NGOs that deals with TB and HIV. From a map we can have an idea or glimpse of the effort and understand which branches we have to strong more.

V. Sum-up of discussions

Prof. Nazrul Islam, chairperson, HASAB then discussed on the three issues. He thinks policy is the power of any kind of program. So, behind the health service provider TB-HIV combined policy is compulsory. About One thing he was confused that discussion about skill mix. We have to make clear what we exactly mean about skill mix.

He also told that information should be very simple but significant. Both the TB-HIV people are stigmatized and GO-NGOs should work in a full strength for them simultaneously. Dr. Nazrul Islam is the person who mentioned the necessity of gender equality of all the service for TB-HIV. He told that most of the women cannot go to the health center to get support being discriminated and also our social context doesn't allow them to move frequently. We have to bear all these in mind. Not only that, general people have to be informed about all these.

VI. Speech from Chairperson:

LD sir told that we have sensitized lots from this discussion and then he go through some data from the fact sheet. He told that MIS should be containing from local level. We have to practice it from family level that how precisely and in an informative way we can put information and it will help us to develop a modern MIS system. And also it should be practiced in proper way. We don't need to put the so called regular MIS report that doesn't make any sense at all. MIS should be clear and cost effective.

Line Director Sir also mentioned one thing that the head of the health department are thinking of all these issue and now is the best time for us to discuss on this issue. We all should connect in one pipeline all the health professionals, we have to create the road map, have to plan how many people we are going to be trained all this issues should be in the same platform so that our next generation can leave in peace.

6. Conclusion

Strategy and policy according to the discussion took place today needs long time. Though policy is necessary for the provider as it is the strength of implementation we have not enough time in hand. There should be an algorithm so that the clients receive the comprehensive and integrated service which is the only way to minimize disease burden of TB-HIV. TB itself already a stigmatized disease and other hand they are prom to HIV infection and it is also applicable in reverse way. So measures can be taken to minimize stigma and discrimination. GO-NGO service providers are working individually and in different system and format. This round table will open the door to work in a coordinated way which will be more effective to fill the interest of burning topic of the workshop.

7. Recommendation

- ▶ We have to train the service providers on TB-HIV who are working on TB as well as HIV area as the first step of minimizing disease burden of TB-HIV.
- ▶ Existing policy documents should be revised to include co infection concern and to develop action plan accordingly
- ▶ We should develop proper algorithm to reach both TB and HIV simultaneously in GO and NGO level which can be the proper way of skill mix to minimize existing and upcoming problem regarding the issue
- ▶ Strengthening referral linkage giving priority the TB-HIV together
- ▶ MIS should be clear and simpler and in need of review to include necessary column to address TB-HIV simultaneously and exclude the unnecessary portion for proper evaluation.